Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Classification Criteria for Inpatient Rehabilitation Facilities

Monday, February 9, 2009
2:00 pm-4:00 pm Eastern Time

The purpose of this Special Open Door Forum (ODF) is to gather public input on the classification criteria commonly applicable to Inpatient Rehabilitation Facilities, commonly known as the "75 percent rule." The compliance percentage threshold is currently set at 60 percent. Public input from this meeting will be considered in the preparation of the Report to Congress required by the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

Background

CMS has contracted with RTI International to assist CMS in preparing the Report to Congress required by the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). Specifically, RTI will examine and report on:

(1) whether Medicare beneficiaries have access to medically necessary rehabilitation services and any potential effect of the "75% rule" on their access to appropriate care?

(2) whether alternative criteria or refinements to the 75% rule could be used to determine IRF classification, including patients' functional status, diagnosis, comorbidities, or other attributes?

(3) whether IRF care is appropriate for certain other types of conditions which are commonly treated in IRFs, but are outside of the 13 conditions specified in the 75% rule? Are there differences in patient outcomes and costs when these cases are treated in different settings?

RTI's 24 month contract includes two phases. The first phase consists primarily of reviewing the relevant literature and policy materials and compiling stakeholder input. The second phase involves conducting analyses utilizing administrative and clinical assessment data. CMS will be reporting on the first phase in a Report to Congress which is due June 2009. The RTI analysis will continue through 2009 with a final report to CMS by late 2010.

Comments should be limited. Longer written comments may be submitted via e-mail to IRFReporttoCongress@cms.hhs.gov. If possible, comments should be submitted to CMS in writing in advance of the Special ODF. If you have any questions please feel free to contact Julie Stankivic at (410) 786-5725.

We look forward to your participation

Special ODF participation Instructions:
Dial: 1-800-837-1935 & Reference Conference ID: 80702717

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here http://www.consumer.att.com/relay/which/index.html. A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning February 18, 2009.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.hhs.gov/opendoorforums/

Thank you for your interest in CMS Open Door Forums.

Audio File for this transcript:
http://media.cms.hhs.gov/audio/SpcFrmODFIRFRPTTOCONGRESS.mp3

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Moderator: Natalie Highsmith
Leader: Sheila Lambowitz
February 9, 2009
2:00pm ET

Operator: Good afternoon. My name is (Mindy), and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum, Medicare Classification Criteria for Inpatient Rehabilitation Facility.

All lines have been placed on mute to prevent any background noise.

After the speaker's remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you.

Ms. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Mindy), and good day to everyone and thank you for joining us for this special open door forum.

Today, CMS will gather public input from the classification criteria commonly applicable to inpatient rehabilitation facilities also known as the 75% Rule.

Your input from this open door will be considered in the preparation of the report to the Congress required by Medicare, Medicaid and SCHIP Extension Act of 2007.

CMS is contracted with RTI International for a 24-month contract to assist in preparing the report to Congress. The first phase of the contract consists of reviewing the relevant literature and policy materials and compiling stakeholder input. The second phase involves conducting analysis, utilizing administrative and clinical assessment data.

CMS will be reporting on the first phase to report to Congress which is due June 2009 with a final report by late 2010.

We do have an email address to submit your comments. And that is on the announcement that was sent out on the listserv and is also posted on the Special Open Door Forum Web page which is I-R-F as in Frank, reportto -- that's T-O -- congress@cms.hhs.gov. That is irfreporttocongress@cms.hhs.gov. And all your reporting will be placed on the Special Open Door Forum Web site along with the transcript and will be accessible beginning February 1, 2009.

I will now turn the call over to Ms. Sheila Lambowitz.

Sheila?

Sheila Lambowitz: Thank you very much, Natalie, and thank you all for attending. I know that this is a business time of the day and I appreciate the fact that you're all taking time out to help us with this project. We have a very important topic that we need to investigate and hopefully make sense of.

I'm going to be turning the podium over to Barbara Gage, our lead researcher RTI. She's going to tell you a little more about the scope of the project and she'll fill you in on what we learned from the town hall meeting we had last week. And then we'll open it up for questions so we can get some input from you. And we really do appreciate your help on this issue.

So thank you and I'll turn this over to Barbara.

Barbara Gage: Okay. Thank you, Sheila.

This is a - the second in the series of stakeholder meetings to collect input on the classification criteria for inpatient rehab facility. And as Sheila said, we appreciate you're joining us today. We are looking for your input. This is work that has come out of the MAMSI of 2007 and which asked CMS to collect input from the wide range of stakeholders involved in these issues.

The legislations directed us to bring to the table practitioners from all different levels of practice with the rehab community including physicians, both the podiatrists and the geriatrician, rehab administrators, skilled-nursing facilities, acute hospital beneficiaries, beneficiary advocate, trade organizations. And this is part of an initial attempt to pull together the thoughts of these different communities to

collect your input and your perspective on the classification criteria for inpatient rehab facility.

The process involved extensive stakeholder input between now and the June 2009 report to Congress. Our goal is to hear from the rehab communities about your perspective on how rehab hospitals should be classified. There's been a lot of debates about the difference between a rehab hospital level of treatment and a skilled-nursing facility level of treatment or similar services provided in the home with home health or in alternative setting such as long term care hospitals. We are looking for you input on these issues as we prepare our report to Congress on the different perspective and summarizing some of the analyses that will need to be done over the next two years.

The last - this is - as I mentioned, this is the second in a series of stakeholder meetings. Last week, many of you may have been on the phone for our town hall meeting. We had representatives from all of the major associations, the hospital association, the therapy association, the medical association and those organizations representing beneficiaries across the spectrum.

We received many comments, and I'll summarize them briefly today and open the floor for additional thoughts on these issues as I - this is an opportunity for you to ask questions about the works that will take place over the next two years, but we're also looking for your input in terms of directions that we could go in conducting this work.

The legislation called for CMS to address three specific questions. And those were in the announcements for the Open Door forum.

The first question asked whether Medicare beneficiaries have access to medically-necessary rehabilitation services and whether there's any potential effect of the 75% Rule on beneficiaries access to appropriate care.

Those of you in the rehab community know that the 75% Rule, which is really a 60% Rule these days, directs the rehab hospitals to have 60% with the majority of their cases falling within 13 select conditions.

So the first question asked whether there are access issues associated with the directors to have 60% of your admissions within the 13th specified condition group.

We've heard from the association last week, some of the associations with some suggestions to look to some of the structural characteristics of rehab hospitals that differentiate them from skilled-nursing facilities. We also heard comments on the use of accreditation program to distinguish levels of care. And we heard from others about potential barriers to access for certain population, particularly in some of those with chronic conditions that also use the acute rehab hospital versus the sub-acute setting.

We are looking for your feedback as clinicians working with this population to help us differentiate between the acute level needs, those within acute hospital and a sub-acute level of service.

The second question that was in the legislation asked whether alternative criteria or refinement to the 75% Rule could be used to determine IRF classification. And the suggestion that was included in the legislation was to look more of patient characteristics, their

functional status, their diagnosis, their comorbidities or other attributes.

We heard comments last week at the town hall meeting that one could abolish the 75% Rule and not specify any conditions or alternatively add additional conditions to that list of 13. And the five the came up repeatedly were the cardiac, pulmonary, organ transplant, cancer population, populations that use rehab hospitals for pain or burn.

So the suggestion was made that perhaps that the 13 conditions might be expanded given changes in the technology and the services that hospitals provide today. But there are still the - I think the more pressing issue of those patient characteristics that identify that acute level of care needs relative to the sub-acute care level.

So we also heard comments from the rehab facility community last week that some of those measures might be measures of functional status, measures of comorbidity or complications, and these are the types of recommendation that we're looking for from the community. In the populations that you're working with, how do you distinguish that acute level patient, the patient who needs acute hospitalization from those that are appropriate for sub-acute level of care?

The third issue in the legislation is whether IRF care is appropriate for certain other types of conditions which are commonly treated in nurse but are outside of the 13 conditions specified in the 75% Rule. We'll be doing some claims analysis to identify the - an IRF by analysis to identify the types of condition that are outside of the 13 conditions and understanding differences in their admission floors and discharge floors, different outcome measures. But we are looking for input from

yourselves regarding the type of populations that are outside of the 13 conditions that are - do need access to care.

Secondly, the legislation in this area asked about whether there are differences in patient outcomes and cost when these cases are treated in different settings. And there's been mixed results in the literature on whether the outcomes that are achieved at one setting versus another are different. A lot of the problem goes back to needing to better measure case mix differences in the population and how impaired they are and medically complex and other factors. Those that have been done have had small sample size issues. So the samples were not robust.

We are again looking for input from yourselves regarding the direction of some of the analysis that will do over the next year and a half.

We are considering using some standardized data that is available from the Care tool. Many of you are familiar with RTI's name over the last few years. We've been working with many of you to collect standardized assessment data in all of the different levels of care, and that may be an option.

But as we said, what we're looking to hear from you are the comments that you would like to - that you think are important to be brought to the attention of Congress and our report to Congress that's due in June and considerations for analysis that we will be doing over the next year and a half. And those comments, while we look for them today verbally, you can also submit them to the email address that Natalie mentioned at the start of the call -- irfreporttocongress@cms.hhs.gov.

Thank you.

Natalie Highsmith: Okay. (Mindy), we are now ready to go to the phone lines for our open Q&A.

If I could just remind everyone that when it is your turn to ask your question or state your comment that you please restate your name, what state you are calling from and what provider or organization you're representing today. And please limit your comments to no more than two or your questions no more than two. If you have more than two comments or two questions, we ask that you get back into the queue to be able to restate your comments or your questions.

(Mindy)?

Operator: At this time, if you have a question or a comment, you can press star and the number 1 on your telephone keypad.

If you would like to withdraw your question or comment, you can press the pound key.

Your first question comes from Margaret Fogg. Your line is open.

Margaret Fogg: Well I didn't imagine I would be first.

My question - well, I guess it's more of a comment. I really like the idea of being able to study those patients that come to rehab for other reasons especially the cardiac and pulmonary patients. Oh, I'm sorry. I forgot to tell where I am. I am at Whitaker Rehab Center in North Carolina.

And we have a lot of patients who are cardiac and pulmonary and because of the comorbidities and the length of stay for - at the acute hospitals, a lot of times they are more debilitated than the stroke and brain dysfunction patients. So I think it would be really, really good to be able to study those patients and see how their outcomes compare to those patients who go to skilled facilities or to go home with home health.

Barbara Gage: Thank you.

Next comment, please.

Operator: Your next question comes from the Marjorie King. Your line is open.

Marjorie King: Hello. My name is Dr. Marjorie King. I'm a physician at Helen Hayes Hospital which is an acute inpatient rehab facility in the Metropolitan New York area. I'm also the past president of the American Association of Cardiovascular and Pulmonary Rehabilitation and I have a part-time private practice in cardiology.

This really - this I have a comment - actually, two comments that follow up on that previous person's questions and comments.

Both AACVPR and Helen Hayes Hospital submitted letters last week to CMS where we reviewed the literature that is available about referral of patients to IRF who have cardiac or pulmonary disease.

In that letter, we mentioned an article by (Vincent) and colleagues that evaluated the functional and economic outcomes in elderly cardiac patients this discharge to IRF versus SNF environments. As a practicing cardiologist, I also noticed what (Vincent) and colleagues

observed in their article. That is that patients who are discharged to an IRF environment have a shorter length of stay -- typically 10 days compared to 30 days -- are less likely to be admitted to an acute care facility or to an emergency room for evaluation during their stay.

And interestingly, I observed that patients who are discharged to sub-acute or SNF environments compared to IRF environment take longer at home after their home to get back to their usual high-functioning independent self.

I feel strongly from just my clinical observation as well as my experience over 25 years that these patients do much better in an IRF setting. Now that said, trying to look for a literature that proves this is very, very difficult. It's unethical to randomize patients given our current clinical practice environment, too, and IRF setting versus a sub-acute setting.

And it's also very difficult with existing databases to compare patients, comparing - controlling for comorbidities, but also just comparing for functional status. We've struggled with this for 10, 15 years here at Helen Hayes Hospital and have not come up with a good solution.

The other thing that I've noticed is that there are data registries for discharge. For example, for our patients after open heart surgery, there is a society for thoracic surgery registry that tracks patient outcome. But unfortunately, their data point related to discharging patients is either a data point for discharge to home or a data point for discharge to an alternative setting and lumps acute rehab, sub-acute rehab and long term care facilities together.

I would support the establishment of data point, a definition of a data point that is admission to an IRF persist admission to a sub-acute facility versus admission to a SNF or others or for home care it can incorporated into databases such as the Society for Thoracic Surgery. Why reinvent the wheel? Why reinvent a registry? And I think that if this could be done at a society level and perhaps with support from CMS and RTI that that might be one way to analyze the data and the outcomes for these patients.

Thank you.

Barbara Gage: Okay. Thank you. That's very helpful. And we do have that article. We are certainly looking at it. And, you know, well, I'm sure we'll be talking more about that as we continue to work with industry representatives and get more input. So thank you very much.

Operator: Your next question comes from (Andrea Haffle). Your line is open.

(Andrea Pfaffl): Hi. I'm calling from Aurora Health Care in Wisconsin. I have two comments.

The first thing is we will be submitting formal written comments later today. But one thing we're proposing is getting a catastrophic illness category to the CMS 13. And what this would be would be something along the lines of a patient who had an acute hospitalization just prior to inpatient rehab for about, you know, three weeks. You could specify a timeframe.

And these are very medically complex fragile patients who are not safe to go to a nursing home afterwards. And along with this three-week hospitalization, they would have another complication. You know, you

could have a list of, you know, a GI bleed requiring transfusion, respiratory failure, sepsis, acute renal failure, multi-system organ failure, I could go on and on with the list. We have about hand that we would include in that.

So we proposed something where it would be a 14th category that would be a catastrophic. These patients are very medically fragile. We do not feel right or ethically safe sending them to a nursing home. And they do often require that intensive rehab because they have been in the hospital so long.

So that's my first comment and like I said, that will be outlined in our letter that we're submitting letter later today.

The second thing I'd like to comment on is joint replacements being virtually extinct from inpatient rehab. We have experience denials here and are very proud of the fact that we have appealed 26 cases and got all of them overturned. We agreed that most joint replacements to do not require inpatient rehab. In fact, for our facilities, less than 1% of our patients are joint replacements which may not - is actually below national averages.

That being said, there are still handful of patients that are better served in inpatient rehab. And we feel very strongly that CMS needs to look at this virtual extinction based on diagnosis.

You have in the CMS 13 the Bilateral 85 or Older Morbid Obesity Category, yet, those are cases that we received denials on. And again, we're very proud that we appealed those and got those all over turned. But what a process it was to do that and how unfortunate for our beneficiaries to have to - had gone through that.

So again, to virtually make joint replacement extinct from inpatient rehab is something that CMS needs to look at because it's just morally, ethically it's not right to just say across the board joint replacement; no, they don't need inpatient rehab. There is more to the story. And our physicians know what is in the best interest of our patients; therefore, we are still willing. Again, our numbers are low, less than 1% of our patients are joint replacements, but we are still fully willing to bring those patients and appeal those cases if necessary because it's in the best interest of our patient.

Barbara Gage: Thank you. If you could in your comments that you submit electronically to the email site, if you could also specify the types of patients. You say that most do not require acute rehab but some are better served, and that's what we're really trying to get at.

We will be having a technical expert panel in about two weeks and I'd appreciate seeing everyone's comment.

(Andrea Pfaffl): Okay. Thank you.

Barbara Gage: And Dr. King, as you spoke about the comorbidities and the functional status, if you could put together a put together a few comment, more specifics than that, that would help us identify the types of populations where access is really important and (impetus). Thank you.

Natalie Highsmith: Okay. Next comment please.

Operator: Your next comment comes from (Donna Dougherty). Your line is open.

Deborah Schneider: Actually, this is Dr. Deborah Schneider and I'm the Medical Director of the St. John's Regional Medical Center, Acute Inpatient Rehabilitation Facility.

I would like to first say, I agree with the other speakers. We have the same issues with the medically complex that they're still fairly acute, they need relatively frequently daily, if not even more frequently than that medication changes while they exercise.

And I think it was a very apt analogy that one of the physicians told me last week when I was talking to them about how we start exercising people. It's like a wagon when they're sitting still, laying in bed in the acute care, things look fine. But we get them up in acute inpatient rehabilitation and all of a sudden, the handle is shaky, the wheels are falling off. And I think that actually describes what happens with patients when you start having cardiopulmonary stresses and fluid shifts that are occurring.

Along those lines, I'd like to talk about the surgical versus the medical patients.

The surgical - the post surgical patients such as in the hips and the knees along with all the other types of cardiac surgery, these patients have been given a lot of IV fluids, they're often in the geriatric population, and I'd like to comment that I think 85 is a very stringent cutoff and that age should be looked at.

In any case, they're really going through a lot of acute changes. And even though there may be mimesis or standby assist contact guard, in this category when you start getting them up, the type of gait that they're having is usually not very functional; it's used - it's very - no, I

shouldn't say usually, but it's frequently small, timid, fearful steps. And it's - the fear factor puts the patients at risk for fall. And there is now way of really - that we have yet to explain the fear. And the fear comes from these medical - oftentimes from these medical fluid shifts and changes that are going on that are subtle in someone's system.

So in that respect, I think when we see these post-op total joints and cardiac patients and all the other surgical ones, there are a lot of - I'd like people to really look at that category a little differently because they are very acute. And to send them out while those changes along with many of them are new anticoagulants or having had changes in their anticoagulant status, I just think it's very tenuous. They have new surgical wounds, you're applying stresses and their, you know, INRs are not stable, there's still more acute risks for deep vein thrombosis. And so in terms of the replacements and the age and their functional status, I think all those things need to be considered.

In addition, I'd like to add that I'm 100% behind the medically complex. I actually three weeks is too long. I think anyone who's had cardiopulmonary issues that have gone on for even 7 to 10 days, sometimes they're are so debilitated and they're really in a state where they're too good for an LTAC but sort of at that (mimesis) contact guard level, maybe standby assist even, but they're just not medically stable to transfer to a skilled center. They need to be close to the acute care physicians in order to actually save money and particularly if the rehab center has a close tie.

So I think all those things need to be looked at in these patients. So thank you very much. And I'll put this in writing as well.

Sheila Lambowitz: Thank you very much. We appreciate your comments.

Operator: Your next comment comes from David Weingarden. Your line is open.

David Weingarden: Yeah, hi. My name is Dr. David Weingarden. I'm the Medical Director of the Rehab Program at Henry Ford Macomb Hospital. I have one comment and one suggestion.

As a follow-up of the previous physician, I strongly second the concept of a classification of patients that are deemed medically fragile. The - we are frequently seeing patients that are (unintelligible) elderly, have multiple existing medical conditions. I guess we're on top of it, such as an example a loss of half their blood volume or they have a serum albumin which is almost incompatible with life, and Coumadin binds the albumin so it very significantly impacts their ability to get control of their anticoagulation.

They have multiple issues. They're medically fragile although not technically medically unstable, per se. They are potential to easily become medically unstable, but the moment as was commented earlier, as long as things are status quo, they're tenuous and they're medically stable. But now we're going to exercise and make them work in ways we probably haven't worked in years to get them going again. And the potential for medical instability, the catastrophic nature is very high. And it is inconceivable, it's immoral, it's unethical to send these patients to a sub-acute environment where they don't have the type of medical support needed in case they develop these types of problems.

We also had about 28 denials for patients and we also were able to battle through the process and almost - probably 70% of them is administrative law judge level. We're able to overturn them and 30%

prior to administrative law judge level. They were - but it took enormous amount of effort, enormous amount of time investment in each and every one of those appeals or three different levels of appeals; it's a very complex-involved process.

So I agree the medically-fragile concept is a very valid one and should be strongly looked at.

Medically complex is not an appropriate term according to (UDS) staffers at the CMS Helpdesk. They have instructed us that the medically-complex classification is only when the medical care is greater than the rehabilitative care being provided during a rehabilitation stay. So there needs to be a category for the very medically fragile because they're appropriate for inpatient rehab.

As it is, about 12% of patients and actually about one in eight on an inpatient rehab unit are going back to medical-surgical floors. So this is an unstable sickly population.

My suggestion is at presently, Medicare tracks our IRF pie data and also from the skilled-nursing facilities their RUG data. And I have yet to see any reports of RUG data, a patient is referred for sub-acute rehab as to how many of them ends up being readmitted into acute med surge for medical complications, what the mortality rate was and what's their discharge to independent community-living rate was.

So you can say, here's an inpatient rehab, here's skilled nursing facility RUG data on a large scale -- not these little small scale studies and compare the data of which diagnoses are just as successful when (unintelligible) existing selection process and the skilled-nursing facility, which ones are more costly or equally as costly.

Medicare has data. They should be able to look in, if not to modify, suggestions to modify the data collection process so that they can look at morbidity, mortality and outcomes of both the skilled nursing facility, sub-acute programs versus inpatient rehab.

Thank you.

Barbara Gage: Thank you, Dr. Weingarden. That was part of the works that we're hoping to do during the coming year. One of the issues in the past has been the difference in the measures on the RUG data versus the IRF pie data, making it difficult to ensure that you're looking at the same type of patients.

You referred to the medically fragile population. And in thinking about that, ping-ponging effect, I guess one question that we could use some direction on is the - it seems like part of the issue might be that they're being discharged from the (IPPS) too early if their stability is still fragile. It would be helpful if you or others submitted comments regarding the appropriate time for discharge from (IPPS) into acute versus SNF.

Thank you.

Operator: Your next question comes from Patricia Blaisdell. Your line is open.

Patricia Blaisdell: Good morning. I had a couple of comments. I'm calling from the California Hospital Association.

First, I wanted to echo the comments of my colleague from Wisconsin about the changes that have happened over the past few years in

regards to the effect of the extinction, I think as she put it, of the lower extremity joint replacement patients from the acute rehab units.

We've had a very similar experience here in California with third party reviews, both from the fiscal intermediaries and the recovery audit contractors where a high number of cases were denied resulting in, I think, a lot of concern about accepting these patients. And ultimately, that virtually all of those cases that are taken to the (ALJ) level are turned over in favor to provider.

So I think that that database of all those cases that have been denied upfront but ultimately approved may also be of use here in terms of looking at what items were successful in helping support that the patient did belong in acute rehab.

That's just a comment I wanted to pass forward because I think that does also speak to the danger of (couching) our admissions protocol in terms of diagnosis when it is certainly a much more complex decision process and we do need to accommodate the medically-appropriate patients from a range of diagnoses.

The second thing was a related comment. We talk a lot about which patients could appropriately be treated in acute rehab and which patients can appropriately be treated in a skilled-nursing facility. But I think many of us had the experiences that the skilled-nursing facilities do range in their abilities to provide for these kinds of patients.

Some patients, I would be very comfortable being treated in a skilled-nursing facility that had been - developed their programming in such a way to treat this, for lack of a better word, SNF rehab level patients or in some other parts of the country turn sub-acute rehab. And yet what

we're finding is that the reimbursement for the medically complex patient in a skill setting is very poor. While therapy units are accommodated, medical complexity is not.

And those higher-level SNFs that are able to provide care to these in-between patients are going away very, very quickly. And I wonder, as we talk about which patients below where, we can't do that without considering that the other options are available. What is CMS doing to ensure that those patients that they identify is not appropriate for IRF are going to get appropriate levels of care in the skilled-nursing setting.

Sheila Lambowitz: Thanks Pat. Those comments are very helpful and we'll keep them in mind as we continue doing the research.

Operator: Your next question comes from (Linda Deyoung). Your line is open.

(Linda Deyoung): Thank you. And I have one suggestion and one comment.

And I'm at First Health Moore Regional Hospital in Pinehurst, North Carolina and one of my directors, (Pauline Starlowe) has suggested that there are several categories that could be eliminated since the first-time of admissions for infants on developmental disability, congenital deformity and burns are consistently listed at 0% to less than 1% every quarter on (UDSs) and e-rehab data reports. And she thinks and we all agree and concur with her that cardiac just as some others have said should be added to the 60% rule. We have observed so many times that not all cardiac patients can return to their home setting without that brief period of inpatient rehab.

So those are my suggestion and comment.

Barbara Gage: Thank you.

Operator: Once again, if you have a question or comment, you can press star and the number 1 on your telephone keypad.

Your next question comes from (Andy Wittner). Your line is open.

Operator: (Andy Whitener), your line is open.

Natalie Highsmith: Hi, (Andy)...

(Andy Whitener): Yes. I'm sorry. I had it on-mute here.

I am in Florence, South Carolina at Carolinas Rehab Hospital. I have a couple of comments. You can hear me okay?

Natalie Highsmith: Yes, we can.

(Andy Whitener): Okay. Just to go along with, I think, what Dr. Weingarden was saying, one of the things that I found that is not factored into admission is the issue that a rehab nurse (wrote up) some time ago in several of our industries' articles called Failure to Rescue. And we may take a patient that is
medically-complex, they may look stable and some may argue that they could go to a SNF, but they have such medical complex history that if we were to put them in a SNF, you know, they may not - if they do have problems, they wouldn't be rescued, is the concept.

I run a rehab hospital in the same building with a skilled-nursing facility and, you know, if you're going to have a service that is not a

financial drain on organization, you just can't staff a SNF at the same level that you can at rehab hospital with RN. So that is one mechanism that could factor into what types of patients you could take and what type of medical history should be put into a SNF versus a rehab hospital.

The other thing that was mentioned at the very first of the call was the concept of access to inpatient rehab. And I think in a lot of ways access hasn't' really been impacted. At least if you were to ask beneficiary it's the issue and it has in some situations, but the issue has been whether the providers have been denied payment for the services they provided when you do a post-payment review and they deny the service - the beneficiary got access but the post-payment in (denials). I'm not sure they've been factored in.

That's my comment. Thank you.

Barbara Gage: Thank you.

Operator: Your next question comes from Joe Caroselli. Your line is open.

Joseph Caroselli: Thank you. This is Joe Caroselli. I represent Idaho Rehab Hospital in Boise, Idaho.

I agree with many of the remarks of the former speakers and (I've) submitted a report from our hospital that we hope you received. One of the points we want to make is that we should be talking about a rehabilitation provider and the characteristics of the rehabilitation provider. And I don't care how intense a rehabilitation provider is. They also can do less intense services. An example of that would be a stroke patient who comes in to an acute care hospital receives

diagnostic and life-saving treatment, referred them to inpatient - or that IRF may work on the patient trying to help the patient walk, swallow, eventually return home somewhat independent. The patient then will come back to the facility for outpatient care, maybe continue to work on speech and maybe even driver's training.

So intensity needs to be understood as not the number of hours of let's say PT/OT and speech, but the comprehensiveness of the services that will help the patient become independent and live a productive, useful life.

So what I would like to see the study result in is a definition, not of SNF provider or an LTAC provider, home care provider, but a rehab provider and a rehab provider then who can take a patient through a continuum of services at all different levels with the proper reimbursement being applied at the appropriate time.

What we have right now is a very unstable rehab market. That rehab market is denying access to patients to rehabilitation care. Doctors and providers are leaving the field inpatient rehabilitation and I can promise you though I can't - I can't find a research to substantiate this, but as provider in a small community in Boise, Idaho, seven inpatient of physical medicine doctors are now spending very little time in inpatients and very little time in SNF and most of their time is spent in outpatient.

So I believe that what we would need to do is to define what a rehabilitation provider is, meeting the needs of patient and having the services benefit patients and society.

That's what I'd like to see. Thank you very much.

Barbara Gage: Thank you.

Operator: Your next question comes from Elizabeth Wall.

Elizabeth Wall: Hi, I'm calling from the Rehabilitation Institute of Michigan in Detroit. We're aligned with a large academic medical center and were' obviously in an urban setting, and I'd like to comment on the notion of this medically-frail group of patient.

When I look at my outcome data, I consistently see that we have about 15% of our admissions in that group of patients above and beyond any benchmark I can find nationally. So this is a group of patients that we see quite a lot of either because they don't have healthcare, and so they've gotten themselves to a point where they're very debilitated and they're very frail, or they don't have a good discharge disposition options.

The other thing we see was this group of patients is a very high rate of transfer back to acute care. And we're consistently running about 7% higher than any benchmark that I can see in the nation. And again, I think it's because these patients are so debilitated, to send them to a skilled-nursing facilities I can't even provide a level of service for them in terms of their stability.

The comment that was made earlier about the analogy to the wagon is very apt. They appear to be stable on admission, but as soon as you put them to a heavy exercise program, that's when the wheels start to come off and that's when they become unstable and then in my case, we often are forced to send them back to acute care.

So I think there truly is a need for that classification of patients. And I think it would be easily to identify those patients in terms of how long they've been in acute care, what the pretty morbid condition of that patient was, what some of the complications are. I don't think that would be difficult to define it at all. And I think you would see in certain parts of the country or in certain urban settings that you'd see a markedly higher percentage of those patients.

So that would be my comment.

Barbara Gage: Thank you.
The issue of the pre-morbid conditions and the complications there are, you know, the elderly population has a lot of comorbidities. It would be helpful if you said a few words or submitted a statement regarding the types of conditions that you identify as marking that debilitated frail rehab patient, the patient who's healthy enough for acute rehab but has these complications.

Elizabeth Wall: We'd be happy to...

Operator: Your next comment comes from (Beth Poltorek). Your line is open.

(Beth Poltorek): Hi. I'm calling from the Cleveland area and our question or comment actually was as we're looking to see what other diagnoses we might be able to include in the category to the 60% Rule, we're looking at transplant patients and wondering if that's something that other people are seeing as well.

We're part of the Cleveland Clinic Health system and we get referrals for heart transplant, lung transplant and kidney transplants, but there's

really not a clear category that fit those into and we're finding that there is, you know, a great need for rehab for those people.

((Crosstalk))

(Beth Poltorek): The other thing is - the other diagnosis will be critical illness myelopathy and neuropathy. We're seeing more and more of those as well that we'd, you know, like to see a category for.

Barbara Gage: Thank you. We heard quite a bit from the associations and other folks last week in the town hall meeting of the concern over the transplant patient. Thank you.

Operator: Once again if you have a question or comment, you can press star and the number 1 on your telephone keypad.

And we have a follow-up comment from Dr. David Weingarden. Your line is open.

David Weingarden: Yes. Thank you.

The another commenter raised the very critical points that skilled-nursing facility sub-acute programs have no requirements. It is a designation that is almost factitious. There's a reference to it in the Medicare Benefit Manual. It's just being something a skilled-nursing facility that will generally provide two hours of therapy well I think five days a week, but it's not a requirement. So we have nursing homes who are popping up sub-acute units and, you know, present quotes. Is it another marketing mechanism if there's no control over what's actually being provided to the patient and hence, without standards? I mean the inpatient rehab has a standard of three hours of

therapy five days a week as a minimum. Skilled nursing facilities do not have that for sub-acute patients.

A patient may be appropriate for sub-acute unit often at (unintelligible) they have to go to the first available one that's open as they only got an hour a day, three days a week or two hours a day, three days a week for 20 days then their Medicare days lapse. They should be staying forever in the nursing homes.

So our concern is that since there are no standards of what a sub-acute unit must provide and there is, to my knowledge, no tracking of outcomes, there's everything in the world for them to gain by taking these patients and no penalty to pay or no negative outcomes by not succeeding at sending that patient home. Or if they become sick, they simply just send back to the hospital. It's no sweat off their back; if they expire, they expire.

So that our concern is that we're being held to a very strict level of accountability. We're told to utilize another provider being (unintelligible) skilled-nursing facilities to have no level of accountability. And there seems to be a tremendous disparity in that and that has to be rectified for the patients, for the Medicare beneficiary while they're on welfare because they are not protected. They are not protected they're going to get an outcome, they are not protected they are going to be provided to care, they're not protected that they will be provided in serving medical care as well as a rehabilitative care. So there really needs to be standards for the sub-acute world because partly there was not. Thank you.

Barbara Gage: Thank you. It sounds like it reiterates some of the comments we've heard about the need for accreditation of rehab programs and structural and process measures of quality rehab.

David Weingarden: Yup, agreed.

And then you may also discover at that point in time the price differential is not quite as great as they initially thought it what, because they have to provide the same type of - they have to provide a quality of care that has to meet certain standards, their cost will go up, And, although their payment won't go up, they will find few and few providers that are willing to put out that type of cost for the reimbursement available.

Barbara Gage: Thank you.

Operator: Your next comment comes from Bruce Gans. Your line is open.

Bruce Gans: Good afternoon, this Dr. Bruce Gans from the Casper Institute for Rehabilitation and speaking on behalf of the American Medical Rehab Providers Association.

I'd like to just make an observation about the comments we've heard this afternoon. The vast majority of comments have been with regards to the clinical needs for - or the medical necessity or appropriateness at the level of the individual patients or at least the individual type of patient. And as we commented last week, of course the 75% Rule or 60% criterion is an issue which is designed to focus at the level of the facility in terms of making it eligible for payment as a rehab facility as opposed doing acute care hospital.

So I'd like to just point out that the energy that has been expressed this afternoon, again focuses on what we believe is now the dominant question which is really how to establish appropriate medical necessity criteria that can work at the level of today's medical practice standards and at the level of what's good for the individual patient.

And I'd like to reiterate the comment that dealing with that is really the core problem and letting the inclusion criteria be served as a proxy for medical necessity without any process surrounding it that represents legitimate consensus building or evidence-based practice will never get us any further than where we currently are.

So we do still recommend the creation of the sustainable method of modifying and articulating clearly and operationally useful medical necessity
decision-making criteria that serve patients well, keep the service delivery transparent to the patients, to the community, allow the proper patients to have greater likelihood of being placed in the proper setting.

The second comment I'd like to make is the question that was again raised about whether access has been affected. I just like to make sure everybody understands that there's overwhelming event of dramatic adverse impact of access into inpatient rehabilitation hospitals or units as a result initially of the 75% Rule enforcement and now more recently as a consequence of the fear of failure that the retrospective post-payment review process is, whether it'd be the intermediaries, the Medicare administrative contractor, the recovery audit contractor or any other entity has had an absolutely chilling effect.

The problem is we're blind to the consequences because the patients have received care in some other way or setting whether it'd be a skilled-nursing facility or home health care or outpatient services, but having no systematic way of measuring or even knowing the consequences or even not having to try to look at the data that are available from Medicare long term utilization data and (med part) data resources.

We simply haven't asked the question objectively as to what has happened to these folks. We know they're not being admitted to the rehabilitation hospital to the order of probably over 100,000 patients since the rule started getting enforced. Our clinic intuition and suspicion is the bad things have happened to at least some of those folks specifically because they couldn't get the care that they needed in the setting that would have been more protective and more capable of monitoring and surveying their needs and reacting to them when they happened.

But since we simply hadn't had the question asked as to whether that really happened or not, we're blind to the results. And that obviously suggests one course of research and it's an important line of investigation. But we do believe there's no question that access has been adversely impacted. And I look forward to continuing to provide some input and dialogue to you about this. Thank you.

Barbara Gage: Thank you, Dr. Gans.

Operator: Our next comment comes from Anne Deutsch. Your line is open.

Elliot Roth: Hi. It's Dr. Elliot Roth working with Anne Deutsch at the Rehabilitation Institute of Chicago and Northwestern University. I just

wanted to underscore the comments made earlier about the importance of comorbidities, some of which are, of course, preexisting conditions and some are, you know, dealing with some of the concomitant and secondary conditions that take place during rehabilitation.

There is both, you know, extensive clinical experience with this but also emerging literature about the importance of the comorbidities in the rehabilitation process. Interestingly enough, affecting not so much the outcome as much as the, of course, the amount of resources that's being used and I think all of us, you know, with clinical experience with this understand the importance of dealing with this.

Barbara Gage: Great. Thank you, Dr. Roth.

Operator: And once again, if you have a question or a comment, you can press star and the number 1 on your telephone keypad.

Barbara Gage: Actually, if we could back up a minute to, Dr. Roth, your last comments about the emerging conditions affecting the resource use and that being even more important somewhat than the outcome? Could you say a bit more about the issues there?

Elliot Roth: There is, as I said, growing literature. Not a huge amount, but there's growing literature. And, you know, maybe more important, our own depth experience with this throughout, you know, the rehabilitation community that dealing with the comorbidities during the rehabilitation process is a very important, time consuming, effort consuming, expense consuming enterprise. And, you know, it's for the things you'd predict; it's for lab tests and medications and more intensive monitoring.

And interestingly enough, you know, the - it's - typically, many of those patients with the severe comorbidities do just as well clinically in their outcomes. Of course, sometimes, it negatively impacts the outcome, but many of them didn't do just as well but they often had to stay longer, they often have, you know, they set more of the, you know, resources they get used for it. So, it's in some ways more of a cost issue - as much a cost issue or more of a cost issue than it is an outcomes issue.

Barbara Gage: Thank you.

Elliot Roth: And in many ways, you know, of course, rehabilitation programs affiliated with hospitals or that are in hospitals are in a much better position to deal with those kind of intense problems than are many of the other facilities for these patients. I think that's an important issue relative to access, is that, you know, the hospital-level care is just clearly in a much better position to address those issues.

Barbara Gage: Thank you.

Operator: Our next comment comes from Peter Thomas. Your line is open.

Peter Thomas: Thank you very much. It's Peter Thomas. I'm speaking on behalf of the Coalition to Preserve Rehabilitation. I spoke last week during the call on the same topic and I wanted to follow up today.

I mentioned some of the members of the Coalition last week. It's a fairly broad-based coalition of disability and consumer and rehabilitation organizations. And we have put together some written comments, about seven or eight pages long, and we'll be submitting that today via email.

We have about 20 organizations that have signed on to the comments including the American Association of People With Disabilities, Amputee Coalition of America, the rehabilitation nurses, the Brain Injury Association, the Dana - Christopher & Dana Reeve Foundation, Paralyzed Veterans, UCP, United Spinal, Easter Seals. There's a whole host of groups that are very interested in this issue. So, I wanted to make sure that you were on the lookout for that testimony so that you can incorporate that into the proceedings.

I wanted also to follow up with - from what Dr. Bruce Kahn said because I, too, have been listening to the speakers on the call and it does appear that there is a fairly heavy reliance or focus on medical necessity.

And just to - again, I mean, obviously, medical necessity is an extremely important issue in the inpatient rehabilitation hospital and unit setting. But it is separate and distinct from the 75% of 60% rule, and it is the coalition's view that it should be.

Again, one more time, the rule is designed to classify rehabilitation hospitals and units to determine whether they're paid under a separate payment system from the acute care hospital system, not to determine whether a particular patient is medically necessary for the inpatient rehabilitation environment. And it's when you get into that melding of those two very distinct and separate issues that we view many of the problems that the 75% rule or 60% rule has created really come to the fore.

So we would just once again ask that you keep very fresh and clear in your mind the fact that this is a classification tool for purposes of

payment and determining how a unit or a hospital is paid and look to design or redesign a system that really goes to that issue, not to what kind of patient is medically necessary, what particular type of patient is medically necessary in that environment. That's a whole separate system and there's a whole set of requirements and detailed regulations and manual provisions about who is medically necessary for purposes of IRF care.

As everyone on the call probably well knows, there has been a tremendous effort and counter effort in the past three or four years to both deny claims for specific patients and to appeal those claims. Depending on where you stand or sit on this issue will determine how you view it. But the fact is that there's been quite a struggle taking place to figure out exactly who is appropriate for case in this environment. And to mix those two things one last time, to mix those two things we view as part of the problem, not part of the solution.

I heard it's said that there will be a technical expert panel meeting in the next two weeks. And I would just, I guess, ask or, if you're not prepared to respond, then certainly to keep this in mind, that I don't know how you become an expert in this field, but some of the people that I view as being most expert are the people who have gone through the care themselves. And so, consumer groups, disability groups, I sure hope that they're being represented on the expert panel because, in some instances, those are some of the people that really experience first hand inpatient rehabilitation and what it can mean in their lives.

I don't purport to be an expert, but I do purport to be a former recipient of inpatient rehabilitation hospital care for a two-and-a-half month period, 1974. After a car accident that I was in, I dared say that I would never get two and a half months of inpatient rehab under

today's environment. I recognized that. The setting of care really has changed over the years. But the fact is that if the consumer and disability perspective is not represented on the expert panel, I would hope that both RTI and CMS would make combinations for that and ensure that that voice is heard.

Finally, I just want to say that if the outcome of this study is to ultimately determine how to classify IRFs and determine which ones are inpatient rehab hospitals and units again for purposes of payment, we would certainly hope that you would spend some significant time looking at alternatives to the current diagnosis-based rule.

We don't believe in the diagnosis-based rule; we think it's a superficial and, frankly, simplistic and mechanism to determine what can be a very complex topic. We think there is a number of different ways to assess how a hospital unit should be determined to be inpatient rehab hospital or unit that don't include looking at diagnosis.

And so we would favor a function-based approach. We would even favor an approach where people go actually into the environment itself much like in accreditation model or something along those lines perhaps as a second tier of investigation to ensure that the hospital truly is providing rehabilitation - intense rehabilitation services that are coordinated and that really are meeting the needs of patients in that type of an environment, rather than kind of prophylactic kind of rules and mechanisms that don't really get to the nub of what that hospital is really doing.

And finally, the comorbidities policy, to talk about this current policy when we're talking about looking at alternatives to the 75% rules doesn't really make a whole lot of sense. But having said that, in case

the decision is made to continue with the existing policy, we feel that we have to make mention of the comorbidities policy.

Right now, while it's extremely important that CMS look at comorbidities in terms of determining whether particular patients are appropriate for inpatient rehab, and here I am melding medical necessity with classification, but that is the function of the rule at this point. I mean that's what's been happening to this point. So let me just say that the fact is that the current comorbidities policy doesn't make sense. It basically states that whatever comorbid condition is there has to independently qualify the patient under the 75% or 60% rule. And we feel that doesn't make sense. We feel that patients need - you need to look at the totality, the circumstances of the patient and not rely on that rule which we view as being flawed.

Not at all saying that comorbidities are important. In fact, it's the opposite. We feel that every patient in an inpatient rehab environment for medical necessity purposes has to be looked at with the totality of the circumstances, and the rule, that is currently, you know, the 75% rule, to determine classification we believe is flawed because of this issue about this, the comorbid condition being an independent factor, an independent qualifier for that patient to be considered on the rule.

So that you for your time, and again we're going to be submitting these written comments today.

Barbara Gage: Great. Thank you for your comments. I'd love to see the criteria that you propose as alternatives to the diagnostic-based rule. Please do send them in. And the issue that you raise and that Dr. Kahn raised and others, so breaking apart the provider classification from the patient's medical necessity is something that just, in the Congressional directive

to CMS, they are - they did request that there'd be discussion of whether patient's characteristics might be useful in developing alternative criteria and considering the - they also asked for consideration of outcomes of similar patients getting rehab services in different types of settings.

So, while it is - while they are two separate issues, Congress is interested in information on both. So thank you for highlighting that and please do send in your criteria.

For all of you who are submitting comments, if you could submit them in the next week, that would be useful. Then they could be included in the technical expert panel discussion.

Natalie Highsmith: Okay, next comment please.

Operator: Your next comment is from Renee Thorsvold. Your line is open.

Renee Thorsvold: Hi. This is Renee Thorsvold calling from Ohio State University Medical Center. And this goes back to the very first comment, I believe, from Ms. Fogg at Whitaker, and she was urging for more study with the cardiopulmonary patients and including them as kind of a more traditional rehab patient.

We support this because we are at Ohio State and we're connected with a large heart hospital. We see a lot of patients that weren't even around in the past. They've had implantable devices such as like a BIVAD or an LVAD, and these are folks that are going to need a lot of care -- patient teaching, medical surveillance, or just machine-related testing, monitoring, you know, special considerations of that kind of a

patient's endurance. And again, these are people that we didn't even see in the rehab industry before, you know, just several years ago.

The other group that I just wanted to bring up was the amputation impairment group. You know, that is one of the diagnoses that's included, but we are also part of a large cancer hospital at Ohio State and we're seeing more and more patients with hip disarticulations and hemipelvectomies due to cancer.

And currently, those patients have to be considered just like an AKA, which does not account for special features that they're going to have with balance, mobility, feeding, and positioning, skin wound issues, things like that. So these are folks that are going to have a higher level of medical monitoring just because they're the oncology patient. So we'd like to just see expansion of that group of patients within the amputation group.

Thank you.

Barbara Gage: Thank you.

Operator: Your next comment comes from Joni Breeden.

Your line is open.

Joni Breeden: Thank you. I'm calling from Saint John's Health System in Indiana.

I'm very proud to support all the comments I've heard here today. My background is I'm an occupational therapist. And one of the factors that the physician speaker before last, or I think it was the guy that's, say, rehab speaker, is the beneficiary.

We are down to accepting on average about 30% of the patients referred to us; in the last three months, it's been as low as 8% and as high as 45%. But on average over the last nine months, it's about 30%.

The beneficiaries don't understand. Their families don't understand. They referring physicians don't understand. As hard as we try to explain the 60% rule, to explain medical necessity, we've created a system that the public does not understand and they just feel like the doors being closed on their opportunity to get better and to return home. And it's difficult. It's nearly impossible. And we see time and time again maybe an 87-year-old mom or grandma go to a SNF and we know we could get her home with family in an IRF, but she dies in a SNF or comes back in with pressure ulcers.

Again, the family and the patient have been left out of this equation and I feel, at our facility anyway, many times they just feel like we've made an unethical decision to not admit them and it puts us in a horrible situation.

So again, I want to report I just hope beneficiary, the average consumer, is somehow being allowed to give some comment to this rule, too.

Barbara Gage: Thank you.

Operator: Your next comment comes from Kirsten Jones.

Your line is open.

Kirsten Jones: Yes, this is Kirsten Jones from Health Dimensions here in Atlanta. I'd like to echo some of the comments made earlier from Joe Caroselli, and I believe (Andy Whitener).

In addition, our comment pertains to the review of whether Medicare beneficiaries have access to medically-necessary rehabilitation. The CMS data does not reflect the denials of payments to IRFs. And my question is, will it be reviewed to assess the current and future impact of access to care for beneficiaries specifically?

Barbara Gage: Are you asking whether as part of this work we'll be reviewing the types of cases that were denied?

Kirsten Jones: Yes and no. In terms of looking at the IRFs' involvement, the patient may have case. However, it's denied. And then the question of - that was raised with regards to medical necessity, the 75% rule, how that equation all relates to each other, if there is an impact.

Barbara Gage: Thank you. Is the - we will be - well, I guess we want some clarification. Are you talking about comparing the 60% or 75% rule with the medical-necessity criteria?

((Crosstalk))

Kirsten Jones: ...the Point Number 1, if you're looking at Medicare beneficiaries and their access to care, they may have the care. However, it is denied later. And therefore, there's an adjustment in the industry in looking at those specific types of patients that are denied. That data, our comment is that that's not readily available and does not factor into part of that data gathering that you have to do.

Does that clarify?

Barbara Gage: Well, we are looking at the trends, and we'll identify, as has been done by others, changes in the types of cases that are admitted and how that tracks with the different policies implemented.

Kirsten Jones: Okay.

Barbara Gage: Is that helpful?

Kirsten Jones: Yeah, that's helpful because I think that ultimately, that will impact whether beneficiaries have access to that care.

Barbara Gage: Thank you.

Kirsten Jones: Thank you.

Operator: Your next comment comes from Janet Raisor. Your line is open/

Janet Raisor: Hi. This is Janet Raisor. I'm from St. Mary's Rehab Institute in Evansville, Indiana, and I want to go back to the Saint John's comment about denial rate and hope that your group would look into the cost of the denials that we are all doing throughout the country. And I just think that is a huge when you look at her denial rate at 70%; ours is at 50%. And I think you could go - we are spending money to pay people to go tell them they can't come to rehab, and I think that's a huge cost on all of us so I'd like for you to include that.

Then the other condition I'd like to have some discussion on is we're a Level 2 trauma and we have, you know, the typical 13-type diagnoses with the head injury, but we also have a lot of trauma patients who

need rehab who do not fit into the 13 conditions. And so we do take them, but they're very - they really are considered a debil.

So those are my two comments, the cost of denials and the trauma patient that needs a rehab. Thank you.

Barbara Gage: Thank you, Janet. Can you - thank you. Can you say a word more about the types of trauma cases that are not fitting in?

Janet Raisor: Well, they'll fit in - some of them do fit it for medical necessity, but they'll be the patients that might have pelvic fractures, lung bone fractures, they need pain management, they have anti or - anticoagulant issues. So they really need the medical setting of an inpatient with a physician monitoring and then are not appropriate for a SNF, but they don't meet the 13-condition criteria.

Does that make sense?

Barbara Gage: Thank you for describing the types of services. And how did they fall out of the major multiple traumas category?

Janet Raisor: They don't have - my screener just left, but they don't have enough - she asked how did they find - fall out of the names, the multi - it could just be pelvic fracture with no internal organ problem or anything, but they do need lower lung or femur fracture.

Sheila Lambowitz: Okay. I think we certainly will take your question and just we'll start looking at it and, you know, we'll try to get as close to an answer to that as we can.

Natalie Highsmith: Okay, next comment please?

Operator: We have a follow-up comment from (Andy Whitener).

Your line is open.

(Andy), if your phone is on mute, could you please unmute?

(Andy Whitener): Yup, did it again.

I do want to follow up on the, you know, the loss of patients in the, you know, that have been - the access issue. You know, I think one of the things that most people in rehab are well aware of over the years is that total knee replacement and total hip replacements have been, you know, been moved to different settings -- going to home health, going to SNF. But there's also been a loss and we want you all to take a look at the loss of patients that are being described because of medical - not meeting a medical acuity criteria, which is not actually well defined in, you know, through most of the intermediaries.

But again, a lot of these comments I think come back to what Peter Thomas was saying, is that if we had functional criteria, we know they need rehab, we know that they're medically unstable and they're not going to be as well taken care of in any other setting. But sometimes, the criteria don't delineate that as well as we know when we're taking a look at the patient, and the physicians are looking at where they would want their mother to go if they, you know, if they had a significant issue going on. And again, that brings me back to that issue of failure to rescue and whether we're deciding to put them in nursing home SNF or in rehab.

Again, thank you.

Barbara Gage: Thank you. So it sounds like you're proposing the importance of the functional criteria?

(Andy Whitener): Well, absolutely. I mean, one of the things that - when we first started some of the (LCD) reviews in - when I was in Georgia, it didn't seem to be based on function at all. And that's what we're experts at, is taking care of patients who have had significant injuries, medical but - as well. But the point is, that they've had a significant functional loss and we've done a lot to invest in therapists who have special skills in helping people regain their function and return to their previous setting. At least that's our goal. We don't always hit it, but we do a darn good job of it.

I think the - there is a broad difference in where - what type of service you might get in the nursing homes. But again, most SNFs and nursing homes are limited to the payment as to what level of skill of nursing and therapy they can provide. They may provide, you know, because they get paid a little bit more for the RUGs that have a lot of therapy, but again, you know, I think the skills that they're generally needing are much different than a rehab hospital.

But yes. The functional criteria, I think, is very important.

Barbara Gage: Thank you.

Operator: Our next comment comes from (April Bearb).

Your line is open.

(April Bearb): I had a question. What types of patients are you seeing that facilities are taking that fall within the 40%? Because I'm in Louisiana, and our (FI) pretty much made it clear that we need to see 100% of Medicare patients within the CMS 13 and we need to reserve the 40% for private pay or commercial pay that don't meet the CMS 13. So that was my big concern or question, was the 40%, what's being seen out there.

Barbara Gage: Well, there are different types of cases that fall into that 40%, and part of what we'll be looking at over the next year and a half is how that's expanded or changed as the numbers of the joints and lower extremities have declined.

(April Bearb): Okay. Because right now, I mean, we're at 100%. We cannot have anything else because our (FI) will deny. So, that's been a real problem. If they could standardize the prescreening to like everybody before me has said (unintelligible) some of the questions of what makes a good rehab patient, that would really be beneficial to IRF.

Barbara Gage: Well, we'll look at that. Thank you. That's very helpful.

Operator: Your next comment comes from Renee Thorsvold.

Your line is open.

Renee Thorsvold: Hi again. It's Renee Thorsvold from Ohio State University Medical Center.

This comment goes along with what three callers ago were talking about. And this is about patients that would fit into those 13 conditions but may have, you know, comorbidities that are going to cost quite a

bit for the IRF to take care of. The physician from the Rehab Institute of Chicago was touching on this earlier.

Some of these patients, you know, they fit into the Top 13, but they're going to have diagnoses that could cause a facility not to perhaps want to take them because of the cost of care. And these things I'm talking about are, you know, a non-traumatic brain injury or non-traumatic spinal cord injury patient that has a cancer diagnosis that perhaps would be getting frequent hematologic monitoring, possibly blood and blood product transfusions.

Some of our patients - as I've said earlier we're in conjunction with a large cancer hospital. Some of our patients are going back and forth for chemotherapy, getting radiation during their inpatient rehab stay. These are folks that are very costly to take care of.

And then also, just back on track with the implantable heart assist devices, you know, those folks are going to just need a lot of cost of care, and I just worry that some of these Medicare beneficiaries are not going to have access to inpatient rehab programs because the facility is not going to be able to take on that high of a cost.

So I think that what I would suggest is to just kind of look at the comorbidity tiers again and see if we could possibly add more, you know, to kind of update it, add more of those comorbidities that we're seeing now that are very costly.

Thanks.

Barbara Gage: Thank you.

Operator: Your next comment comes from Anne Deutsch. Your line is open.

Elliot Roth: Yeah, hi. It's Elliot Roth in Chicago again.

Just to build on what Bruce and Peter had pointed out earlier about the need to focus on what defines a rehabilitation unit, I would just question whether there are other models or levels of care that are defined by, you know, as we're being defined by diagnoses or by the, you know, the types of patient characteristics that we're talking about. Does that happen in intensive health care units or LTACs or, you know, other levels of care?

Barbara Gage: Thank you.

Operator: Your next comment comes from (Chris MacDonell). Your line is open.

(Chris MacDonell): Thank you. This is (Chris MacDonell) from (CARF) in Washington, D.C., and I just want to thank everyone for calling in and giving their comments.

Barbara, we sent out comments into CMS, and we would hope that CMS would take at the role of accreditation and specialty areas such as inpatient rehabilitation. And many of the callers on this call have been actively engaged towards the development of the standards as they now exist, and they do deal with all the issues that people have been talking about. So we hope that you will consider looking at those comments closely. Thank you.

Barbara Gage: Thank you, (Chris).

Operator: And once again, if you have a question or a comment, you can press star then the number 1 on your telephone keypad.

And at this time, there are no more questions in the queue.

Sheila Lambowitz: All right, well, this is Sheila Lambowitz again. Again, I want to thank you for participating. You've given us a lot to think about and a lot of promising avenues of research. So we're going to take this back and, you know, add it to our project plan, and we'll be giving you more feedback as we proceed with the project. So thank you very much and have a great afternoon.

Barbara Gage: And over the next week, if you could submit your comment to irfreporttocongress@cms.hhs.gov, then we can be sure to include them in the ongoing discussion.

Thank you again.

Natalie Highsmith: (Mindy), can you tell us how many people joined us on the phone lines?

Operator: Three hundred and thirty.

Sheila Lambowitz: Three thirty. Wonderful. Thank you.

Operator: You're welcome.

This concludes today's conference call. You may now disconnect your line.

END